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Correspondence

Some reflections on the Wendy Savage Case*

SIR

The rather shameful mismanagement of this *cause celebre* by the National Health Service (NHS) and by university authorities at the London Hospital in apparent collusion and the equally shameful silence on the part of those bodies which ought to have intervened to save our professional face, raises a number of rather basic questions about the proper relationships between medical practitioners, their patients, their clients (when not the same person is the patient), their paymaster, and their profession – as represented by the General Medical Council (GMC), the colleges, the Medical Defence Societies, the British Medical Association (BMA), etc.

Nearly everyone would agree that the fundamental unit of medical care is the consultation, as stated by Sir James Spence; and that a consultation represents the sealing of an implicit contract (or covenant as some would prefer to call it) between medical practitioners and their patients or clients. In general practice this relationship is more or less underlined by the structure in which it unfolds; the general practitioner (GP) being an independent contractor and the patient being able to choose his or her own doctor within limits. The importance of preserving this contractual relationship is possibly why, in defiance of administrative logic, GPs have consistently refused to work by assignment to a defined population – perhaps the development of group practice may enable these two points of view to be reconciled.

The relationship between a hospital doctor (whether junior, consultant or other) is much less well defined. Does the patient become the consultant's patient on entering the hospital for the duration of the visit – even though he/she may be largely dealt with by the consultant's juniors; or is the contract essentially between patient and NHS or between GP and consultant, or *ad hoc* according to with whomsoever the patient makes contact at a given time? It matters because the patients or clients need to know to whom they are entrusting responsibility (and the power that necessarily goes with it!) and who is accountable if they feel aggrieved. As things are, while consultants are paid for taking this responsibility, which is often very onerous, it is difficult sometimes to know when mistakes are made who is personally accountable; and indeed, when damages are awarded, they are often paid on behalf of both the management and the professional workers concerned with the case on some basis agreed between the NHS and a defence society. All this needs, if possible, sorting out. I would make the following suggestions:

1. The basic contract is between a primary care doctor (sometimes a casualty officer, usually a GP) and the patient and/or client – if for, instance, a parent or guardian.

2. When secondary care is thought to be needed, the primary care practitioner is responsible for calling in a consultant as a solicitor calls in a barrister when one of his cases goes to court. The duty of the hospital service is to provide for the consultant's back-up and expenses, ie his fee, usually as a proportion of salary, those of his assistants, and the cost of hospital care including the provision of nursing, laboratory, theatre and housekeeping services. There would seem to be a case for separating these costs and for the NHS to hire consultants and their juniors by contract with some formal statement of its terms in each case – including their duty to provide hospital care of a certain recognised standard. It would, I believe, have been better if the health service had been set up in the first place in such a way – as for instance by using friendly societies as intermediaries – to make it clear who was paying for what and who was responsible for what. I suspect that many consultants and their descendants never really took in the fact that after the NHS was set up they were no longer 'honoraries' giving their services for love but paid, if indirectly, with their patients' money as in private practice. I should add that I am aware that this proposed clarification of roles does not state clearly what is the contractual role of a junior doctor or one called in as what I will call a tertiary consultant – as with a pathologist, a radiologist, sometimes a surgeon if the original referral was to a consultant physician etc; nor to whom ancillary workers such as physiotherapists etc are to be held responsible. But it does make it clear that such relationships need definition since without such clarification I believe that we will all slip into the way of regarding our paymaster as responsible for everything that we do (or don't do well enough or at all in our patients' estimation); in which case, administrators will be justified in demanding very considerable powers that could override the personal and professional obligations which go with taking responsibility.

I have also left out so far what is the obligation of the doctor to his profession – as distinct from his patient and his paymaster. What distinguishes members of a profession from tradesmen is their 'disinterested concern' for clients and the fact that as members of a profession they are required to live up to standards higher than those they might set independently for themselves. Membership of the medical profession (sealed by registration with the GMC) obliges us to subscribe to an ethical code which implicity includes keeping up with the

knowledge and skill appropriate for someone of our standing and also refusing to undertake work, even at the patient's urgent behest, which the profession forbids as outside its legitimate scope, as was once the case for instance with abortion and still is as regards so-called euthanasia – even if apparently justified, since a potential patient, when he makes a contract or covenant with a medical doctor, relies on the latter's qualification as a guarantee of skill, learning and professional morals. The contract concerns the profession as a whole since a breach of it gets the whole profession into disrepute, making us less trustworthy and therefore less useful. This is the patient's best guarantee against malpractice, and it suggests that perhaps the defence societies should be run by the GMC and that the GMC in consultation with the colleges should be more actively concerned with defining the new ethical standards that are needed in the light of new technological developments in medicine and changes in public opinion as reflected by the law. The possibly desirable introduction of no-fault compensation will almost necessarily require some adjustment of this kind. Why should the colleges not handle complaints against their members on behalf of the GMC and in close collaboration with the defence societies, leaving the courts as a tribunal of last resort?

Where does that leave the role of the NHS? I suggest that it should have an enabling and facilitating role rather than a directive one and should be run by local authorities on local taxes and negotiated with the so-called caring professions (medicine, nursing, physiotherapists etc) as regards fees or salaries but with minimum standards laid down centrally.

What has all this to do with the case of Dr Savage? Everything, I believe, because what her case has made clear is the existence of structural faults in the organisation and running of the NHS.

But I have not yet dealt with the role of the academic departments – crucial in her case. Obviously the NHS ought, on behalf of patients, to pay the fees of medical academics to the university with their obligations specified at all levels as for NHS staff in relation to clinical duties. Would this lead to difficulties in recruitment as a result of generally lower rates of pay – since presumably academics would be paid at NHS rates for clinical work and at academic rates for academic work? Such anomalies could surely be covered by payment by the NHS to the Department of Education and Science (DES) in order to ensure adequate standards of medical education, undergraduate and postgraduate, and of research, which are essentially national rather than local responsibilities. There could also be a use for distinction awards here. But we should make sure that if a junior lecturer works for a senior academic in the relationship of registrar to consultant for patient care, the latter should have had the same influence on the appointment of the former as would an NHS consultant in the appointment of his or her clinical juniors – whatever the academic hierarchy, which is a different one: otherwise the essential loyalties may not inform their relationship. To return to the case of Dr Savage, anxieties about the clinical competence of someone in her position should surely in future be voiced confidentially through an appropriate college committee working in private with legal advice and after due warning to the person concerned; and colleges, not the NHS administration, should take responsibility for recommending suspension; the duty of the NHS being only to react appropriately to it.

My conclusions are:

1. that the role and function of the different elements providing medical care for our population needs clear and revised definition in accordance with the principle of separating responsibilities and relating to them the powers necessary for their exercise.
2. that there is a need for the colleges in consultation with the GMC to exercise what I see as their proper powers in relation to possible malpractice of any kind, including its definition in their brief.
3. that the profession should set its own house in order before others move in, and wreck it in the process, to the loss of our patients as well as ourselves. I believe that our ideals and standards are in practice and overall higher than those that obtain in any outside person or body, professional or statutory, that might be given a supervisory role in relation to the practice of medicine, and that we should resist any incursion on our autonomy by so ordering our affairs that they are beyond reproach.

*In this case a consultant obstetrician was suspended after compaints by the head of her department that she was incompetent to practise. Dr Savage vigorously defended her position. A judgement is awaited at the time of writing.

Reference

(1) Inch S. Professional incompetence. *Lancet* 1986; i: 864–865.

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Support for Health Workers of South Africa

SIR

We have had an enthusiastic response to our letter, printed in the *British Medical Journal* of April this year, suggesting that a group of British health workers should support our colleagues in South Africa who are making a stand against apartheid.

We have formed the nucleus of a group, provisionally named Support Health Workers of South Africa (SHEWSA). We plan to have meetings on the second Wednesday of each month (except August) at 45 Anson Road, London N1, at 8.30 p.m.

We would welcome to these meetings any health worker interested in contributing to this endeavour.

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